



# WELCOME

SO THAT WE MIGHT BECOME BETTER ACQUAINTED,  
PLEASE COMPLETE THE FOLLOWING.



## Patient Information

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
LAST FIRST MIDDLE

Address \_\_\_\_\_  
STREET CITY STATE ZIP

Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ OK to contact? Yes No

E-mail Address \_\_\_\_\_ Other family members in our practice \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_  
LAST FIRST MIDDLE MARITAL STATUS

Address \_\_\_\_\_  
STREET CITY STATE ZIP

Mailing Address \_\_\_\_\_  
STREET CITY STATE ZIP

How long at this address? \_\_\_\_\_ Own Rent

Previous Address \_\_\_\_\_  
(IF LESS THAN 3 YEARS) STREET CITY STATE ZIP

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
LAST FIRST MIDDLE

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Insurance Information

**A**

Subscriber's Name \_\_\_\_\_ Subscriber's ID # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Group or Local # \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_ Subscriber's Birthdate \_\_\_\_\_

**B (if you have dual coverage)**

Subscriber's Name \_\_\_\_\_ Subscriber's ID # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Group or Local # \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_ Subscriber's Birthdate \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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## Medical History

Physician \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE BEEN TREATED FOR OR MAY BE AT RISK FOR:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> Speech Problems    |
| <input type="checkbox"/> Headaches               | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Prolonged Bleeding         | <input type="checkbox"/> Behavior Problems  |
| <input type="checkbox"/> Heart Disease or Murmur | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Nervous Disorders          | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Endocrine Disorders        | <input type="checkbox"/> Slow in Learning   |
| <input type="checkbox"/> Bone Disorder           | <input type="checkbox"/> Asthma or Hay Fever   | <input type="checkbox"/> Sleep Apnea                | <input type="checkbox"/> HIV / AIDS         |
| <input type="checkbox"/> Eye or Ear Problems     | <input type="checkbox"/> Kidney Disease        |   | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Snoring                 | <input type="checkbox"/> Grinding              |   |   |
- Have you ever had an allergic reaction to any drug or medication? \_\_\_\_\_
- Have you ever taken bisphosphonates for osteoporosis? \_\_\_\_\_

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## Dental History

Dentist \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Approximate date of last dental visit \_\_\_\_\_ Reason \_\_\_\_\_

CHECK ANY OF THE FOLLOWING THAT APPLY AND EXPLAIN BELOW:

- |   |  |
|---|--|
| <input type="checkbox"/> Any injury to the face, mouth, or teeth?                                 | <input type="checkbox"/> Awareness of any gum or bone problems around teeth?                       |
| <input type="checkbox"/> Have you ever sucked your thumb or fingers? If so, until what age? _____ | <input type="checkbox"/> Inability to open mouth wide or move jaw normally?                        |
| <input type="checkbox"/> Do you grind or clench your teeth during the day or night?               | <input type="checkbox"/> Prior orthodontic work or consultation with an orthodontist?              |
| <input type="checkbox"/> Do you have any speech difficulty?                                       | <input type="checkbox"/> Concerned about the appearance of your teeth?                             |
| <input type="checkbox"/> Do you have any difficulty chewing?                                      | <input type="checkbox"/> Are you concerned about the appearance of your face and/or jaw structure? |
| <input type="checkbox"/> Teeth difficult to clean?  |  |
| <input type="checkbox"/> Pain or noise from jaw joint?  |  |

Comments:

\_\_\_\_\_  
\_\_\_\_\_

What is your primary reason for seeking an orthodontic examination?

\_\_\_\_\_  
\_\_\_\_\_

Has an orthodontist been consulted previously? If so, why are you seeking a second opinion?

\_\_\_\_\_  
\_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. This office reserves the right to verify the credit status of potential patient and/or responsible financial parties prior to extending credit for treatment fees.

Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Updates (date and initial) \_\_\_\_\_